ALL STAR PEDIATRICS

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HIPAA Form for Patients 18 years and older

Patient Consent for Use and Disclosure of Protected Health Information & Receipt of Practice Privacy Policy

I hereby give my consent for All Star Pediatrics to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). All Star Pediatrics' Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. All Star Pediatrics reserves the right to revise its Notice of Privacy Practices at any time. A copy of the Notice of Privacy Practices may be obtained at any time by forwarding a written request to All Star Pediatrics' Privacy Officer at 702 Gordon Drive, Exton, PA 19341.

By signing this form, I acknowledge receipt of the office Notice of Privacy Practices. I also consent to allowing All Star Pediatrics to call, email, fax or mail my home or any other alternative contact point I provide and leave a message on voice mail, in person or in writing, in reference to any items that assist the Practice in carrying out TPO, such as appointment reminders, insurance issues, and clinical care (including testing results). I understand that I have the right to request that All Star Pediatrics restricts how it uses or discloses my PHI to carry out TPO. The practice does not have to agree to my requested restrictions, but if it does, it is bound by the agreement. All requests for restrictions must be submitted in writing.

By adding names to the bottom of this form – I agree that they are allowed to receive PHI in the same manner as described above (with the exception of information relating to STD, HIV/AIDS, Pregnancy testing and records relating to drug, alcohol or mental health treatment which all require an additional release).

I may revoke my consent in writing except to the extent that the Practice has already made disclosures in reliance upon my prior consent. I understand that if I do not sign this consent, or later revoke it, All Star Pediatrics may decline to provide treatment to me.

_____ _____ _____
Patient Name Date of Birth Today's Date

_____
Patient Signature

****Now that you have turned 18, you get to choose who may have access to your medical information. By providing an email below, you will receive access to your online patient portal account. You must create your own account before adding parents/guardians/etc. as proxies, and you must add them to your account yourself. Instructions on how to add proxy accounts to your account are available on www.allstarpediatrics.com under the "Patient Portal" star.

Patient email: _____ Patient phone number: _____

Who would you like to receive your annual well check reminder email? ___Myself ___Other _____

HIPAA Approved Contacts (people who we can we speak to about your medical information):

_____ _____
Name/Relationship to patient Name/Relationship to patient

_____ _____
Name/Relationship to patient Name/Relationship to patient